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# Impact of the 2010 Affordable Care Act on the California Labor Force

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# Introduction – The Team & Sponsors

Collaborative effort among health care economists, researchers, policymakers and professionals

# The Situation

- Up to 2.7 million Californians are expected to gain health insurance due to the ACA
- More insurance coverage will lead to greater demand for health care services
- Greater demand for health services will lead to greater need for health workers
- This study asks:
  - How many new health workers will be required due to the ACA?
  - What jobs will expand the most?
  - What skills will be needed?
  - Given continued uncertainty of the future health care environment, how will workforce needs change in different scenarios?

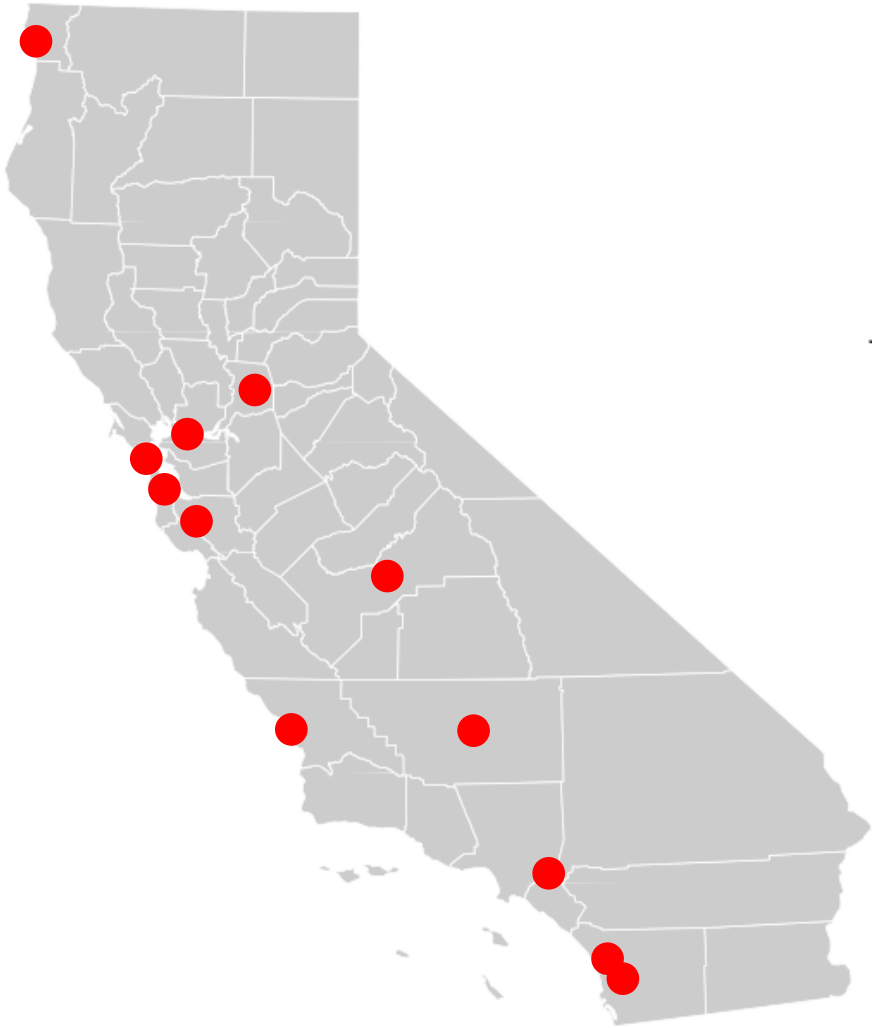
# Three Stages to the Project

- Phase 1: Develop quantitative estimates of how much demand for health workers will increase in California due to the ACA
  - Collaboration between HSI Network, UCLA, University of Minnesota, UC-Berkeley, UCSF, George Washington University
  - Merged the national ARCOLA model with the California CalSIM model

- Phase 2: Consider how changes in care delivery might change the number of workers needed and their skills
  - Interviews with leaders in California
  - New quantitative scenarios based on the models from Phase 1 and the interview findings

# Interviews

- Executive level
- 13 from delivery systems
  - 6 Northern CA
  - 2 Central Valley
  - 4 Southern CA
  - 2 FQHC
  - 1 Rural
- 2 from Associations



*Interviews conducted from 4/3/15 to 5/22/15*

# Themes from Interviews

| | |
|---|---|
| **Metrics** | There is heightened focus on the metrics (quality, costs, patient satisfaction) |
| **Patient Expectations** | Patient expectations are leading to an increased need for patient engagement |
| **Technology** | The benefits of technology do not come without costs |
| **New Vehicles of Access** | The ACA and health care reform have spurred new vehicles of access |
| **Models of Care** | The status quo is no longer a viable option; many are piloting new models of care |
| **Retooling the Workforce** | It's not just about growth, but re-tooling the education system and current workforce |
| **Leadership** | Leadership is needed to respond to the changes and ensure balanced implementation of solutions |

# Themes from Interviews

**Theme #1: There is heightened focus on the metrics (quality, costs, patient satisfaction)**

- Number of efforts focused on Triple Aim
  - Pay for quality
  - Increase access
  - Bend the cost curve
- Reimbursement models are changing
  - Need to meet quality metrics to get paid - or risk being penalized
  - Need to train staff on the quality metrics, but more importantly the rationale for why they are needed
  - Need leadership to ensure quality metrics are being met
  - Need partnerships between hospital and clinics to ensure appropriate follow up to prevent 30-day readmissions; care across the continuum is now becoming a reality
- As patients and employers are now "shopping" for health care, it's important to demonstrate high patient satisfaction and quality scores
  - Need to engage with patients
  - Need to explain/educate patients on treatment protocols

**Impact on Workforce:** need to train staff more quickly on use of technology/interpreting data and rationale for treatment protocols; soft skills to engage with patients; leadership and increased staffing during ramp up period

# Themes from Interviews

**Theme #2: Patient expectations are leading to an increased need for patient engagement**

- Patients own their own care – Providers offer suggestions
  - Health care is becoming more consumer driven
  - Patient needs to be viewed as a partner
  - The patient, family and friend experience is now more important and thought to drive quality
  - Patients are more technologically savvy – some are going to want to talk about information they find on the internet
- Increased cost sharing among patients (increase in Consumer Drive Health Plans (CDHPs)
  - Some patients are putting off or underutilizing benefits
  - Low cost/high quality leaders are gaining market share
- Patients don't understand or know how to navigate complex, uncoordinated care systems

**Impact on workforce:** Need a refresher on customer service skills (not only how to engage but also how to diffuse angry patients) and critical thinking skills. Reorganize workforce to focus on disease mgmt., care coordination. Need navigators, coordinators, and/or concierge services.

# Themes from Interviews

**Theme #3: The benefits of technology do not come without costs**

- Benefits
  - Innovation
  - Digital health – cheaper/quicker service, video visits, apps (improve access)
    - Soon people will be able to take photos of a rash and send to a doctor
    - Will not replace MDs but there are opportunities to outsource algorithms
  - Care coordination
    - Not just about a person but information sharing about patients conditions/health status (internal and external comm.)
  - iPhones, iPad, other mobile apps allow for quick access to information – good resources for staff (ex. HH aides)
- Costs
  - Need cash to acquire and resources to implement
    - Expensive to implement and learning curve is time consuming (EHRs, HIT, other interfaces, ICD10)
    - Extra amount of workflow (before would just write in chart, now need to find right boxes to check off)
  - Need IT staff – hard to recruit talent
    - Top folks want to work for Google or Facebook; or live in ideal locations (urban/high pay environments)
  - Occupational health issues with workforce – increase in obesity, carpel tunnel
  - Shifting workforce from bedside to informatics, not engaging with patients
    - How do you make patient feel engaged through technology?
  - As Technology becomes available, it's not necessarily the most cost effective solution (e.g., MRI vs Xray)

**Impact on workforce:** Short-term - Stress, time constraints, frustration, burnout. Long-term – efficiency, but also occupational health hazards. No one was comfortably commenting on how technology will either impact numbers or types of positions – uncertainty remains

# Themes from Interviews

**Theme #4: The ACA and health care reform have spurred new vehicles of access**

- Increased community health focus
  - Population health and wellness in the community
  - Smaller centers becoming part of the community – lobbies are "community centers"; hire locals
  - School-based clinics
- Development of onsite employer clinics
  - Bring care to the patient; works for large employers
- Technology based visits
  - Digital health offerings – still figuring out what this means (video visits/email/patient portals)
    - Zipnosis – patients call MD/keeps patient out of ED
  - Rite Aid – can push a button to access an MD
  - Telehealth – Mix of early/late adopters; for those that use it – they see the benefit, but need to train workforce
    - Some still in pilot testing phase; not yet reimbursed for these services
- Continued shift to ambulatory settings
  - Hospital-based providers will become more specialized as patients will be sicker
  - Need to train more in ambulatory settings – particularly home health and community based settings

**Impact on workforce :** Need to educate on what skills are needed for population health; teach independence particularly for home health aides; Increase comfort level with providing care via technology

# Themes from Interviews

**Theme #5: The status quo is no longer a viable option; many are piloting new models of care**

- Pilot models are viewed as a cautious approach give uncertainty around anticipated outcomes and reimbursement
  - Paramedic pilot study – paramedics now triaging in the field; work with base nurse or MD to determine best course of action. Care for patients in the home
  - Using more Community health workers (CHWs), the challenge is the reimbursement structure – not sure how to fund it
- Forming narrower networks
  - ACO/ACO like partnerships – to help manage financial risk; each ACO is different so need flexibility
  - Increased relationships across the board – medical groups (OP follow up, assign to medical home through ED), employers)
    - Developing research institutes and specialty-specific centers; provide coverage in areas with no services; helps with continuum of care
  - Many offering an insurance product to manage their employees – managing care and risk
- Other models
  - Team-based care – pilot project with MA as a health coach (funded by Cal Endow); other testing use of a health coach
  - Integrate primary care with behavioral health - focus on addressing more social issues (access to food, shelter); debate – should this be part of health care premiums?
  - Medical home models/group appointments – may not be transferable to all communities
  - How to help employees care for parents that live far away (when working with a large employer)

**Impact on workforce:** Need to learn new skills and to work with new people – face-to-face and via technology; time management (people are now doing more); coping with challenges of change – need people who are nimble

# Themes from Interviews

**Theme #6: It's not just about growth,* but re-tooling the education system and current workforce**

- Disconnect between education system and practice for new grads
  - Most have strong technical skills but need to learn to be adaptable and work on soft skills (interpersonal communication, teamwork, professional dress and expectations)
  - Need to understand changes in the health care landscape (system operations, reimbursement/insurance, business 101) and with increased technology – analytics to understand the full story around a patients health
  - Those with relationships with schools seem to be better at preparing new grads
- Staff are complacent – need to focus on incumbent workers and practice transformation
  - Work at top of license (ex. MAs to draw blood, NPs to work independently)
  - Engage patients as a partner; similar to new grads, current employees need customer service and team based skill
  - MDs need to be comfortable working in teams and giving constructive feedback
  - Continuing education should also focus on IT, quality, health care landscape
  - More training in ambulatory and rural settings
- Just because the focus is on re-tooling doesn't mean we don't need growth for some positions
  - Replacement for retirements and shortage of PCPs – need more NPs and MAs
  - Need some new positions (paraprofessionals, concierge services)
- Turnover not a major concern – varies by geography and position (see strategic considerations for details)

**Impact on workforce:** Need stronger relationships with schools; residency/internships; need onboarding and continuous education in the workplace; need regulation and/or change in union contracts to allow employees to work at the top of their license or beyond. Need to develop job descriptions and training for new positions.

*varies for those with new towers or with high turnover (FQHCs/Rural environments)

# Themes from Interviews

**Theme #7: Leadership is needed to respond to the changes and ensure balanced implementation of solutions**

- Most executive level individuals understand the changes occurring and some anticipate the responses needed to address those changes, but this needs to trickle down to all levels
- Shifting from provider-based to team-based
  - Asking MDs to see themselves as partners with colleagues, which requires new skills and leading in a new way
- Someone needs to drive these changes
  - Education
  - Regulatory
  - Ensuring a balance – focus on quality vs technology vs education vs patient experience
- Engage in health care coalition networks – a lot of changes are happening across organization within a community; there are benefits in working together

**Impact on workforce:** Needs skills in team-based care, critical thinking, decision-making, and providing feedback in a constructive way. Need to determine who is a leader and understand the implications– balance having a care provider vs an administrator due to promotion/new role

# Quantitative Scenarios

Modeling the numbers of workers needed in different scenarios

# Scenarios – Methodology Overview

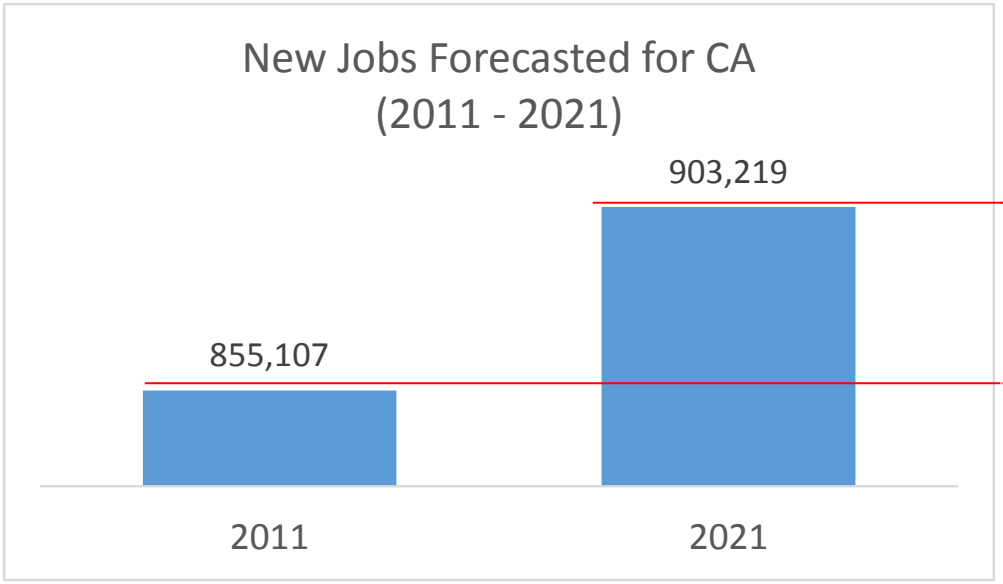
- Many of the interviewees were hesitant to provide quantitative details around workforce changes given the continued uncertainty around the future health care environment
  - We conducted secondary research around utilization and other metrics to help inform the scenarios – see rationale for each scenario
- Scenarios based on percentage changes to growth rates
  - Data were limited to specific occupations, and in some cases, industry, therefore growth rate adjustments are in ranges of high and low percentage changes
  - Percent change for most scenarios ranges from low (10 percentage point change) to high (20 percentage point change)
  - For some scenarios, we took a more conservative approach assuming only a 5 percentage point change

# Baseline scenario

- From Phase I – for context

- The ACA will drive the need for 48,112 new health care and select support care jobs in California by 2021

  - About 6% increase in jobs over ten years as a direct result of ACA




**Only a fraction of jobs needed**

**Does not factor in:**
- **Aging of the population**
- **Long-term Care**
- **Changes to care delivery**

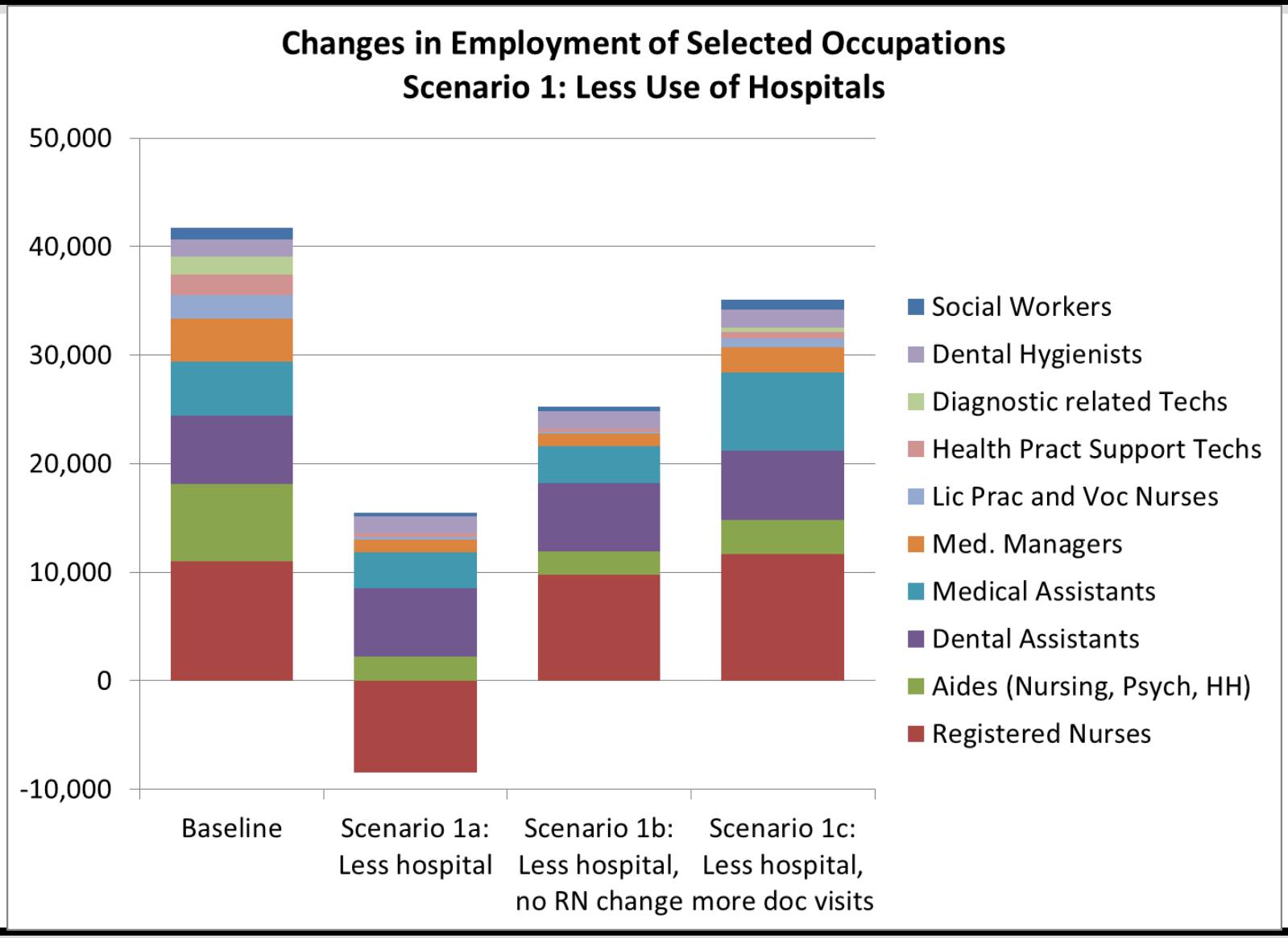
Source: American Community Survey, HSI Analysis

# Scenario 1: Less Hospital Use

- Scenario 1: Slower growth in hospital demand, due to more effective preventive care.
  - 1A. Slower growth in hospital demand
  - 1B. Slower growth in hospital demand but RN staffing holds constant
  - 1C. Slower growth in hospital demand, increase in physician office and clinic use

- Rationale: Continued shift to PCMH and ACOs, which provide preventive care more effectively, and thus should reduce hospitalizations (interviews). We reduced growth in hospital service use by 10 percentage points.
  - Organizations may retain RNs for care management and other roles
  - Lower hospitalization rates may require greater physician office / clinic utilization

# Scenario 1 impacts

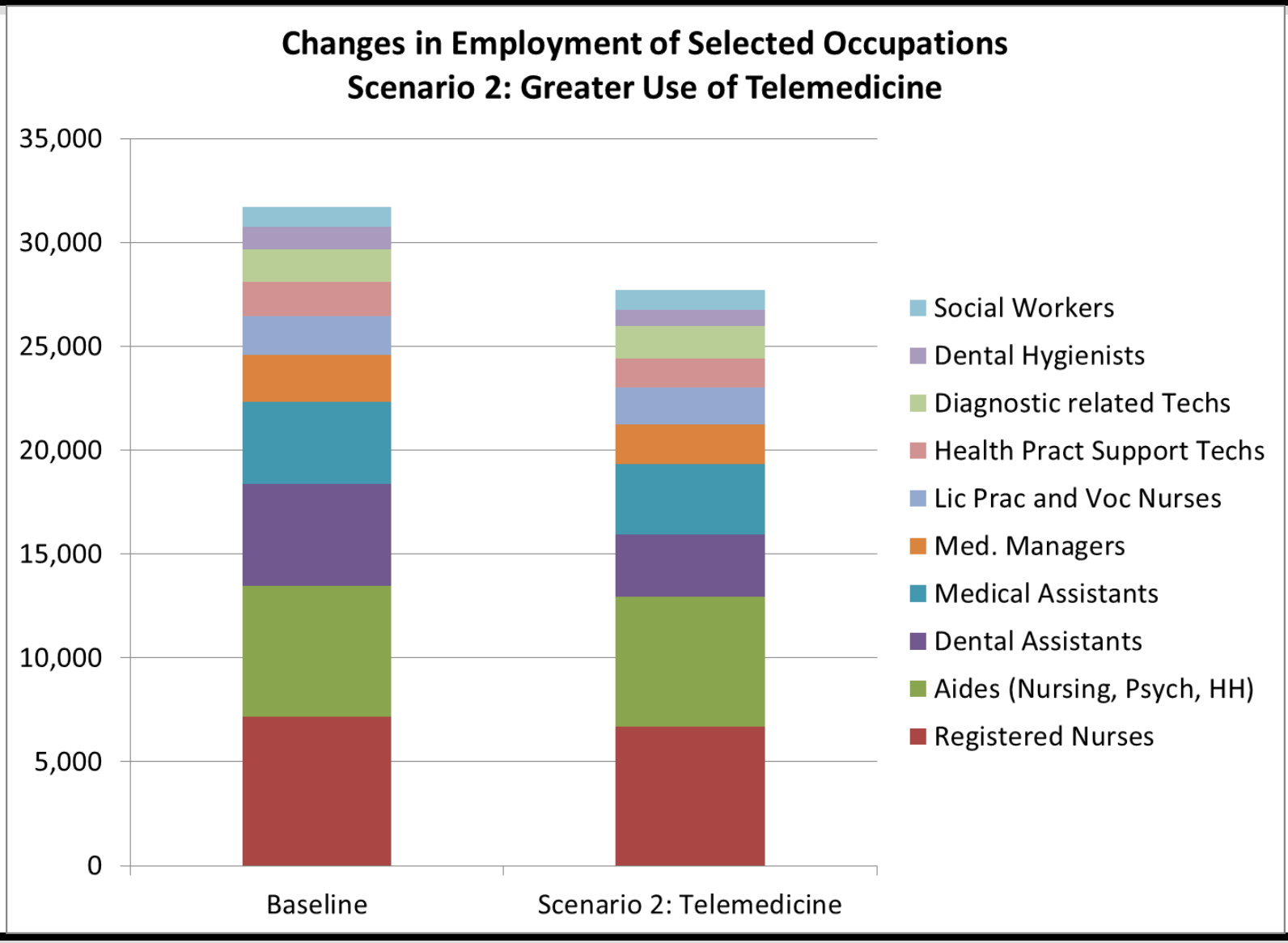


# Scenario 2: Telemedicine

- Scenario 2: Slower growth in physician and clinic visits, due to effective use of telephone, video, and email consultations.

- Rationale: Most interviewees believe we will see an increase in digital and virtual visits, but the extent to which this will impact staffing remains unknown. Taking a conservative approach, we reduced growth in physician office and outpatient center visits by 5 percentage points.

# Scenario 2 impacts



# Scenario 3: RNs in care management

- Scenario 3: Increase in RN staffing in physician offices, outpatient centers, home health, hospitals, and other key settings due to increased case management role of RNs. (Increase RN staffing by 10% in all settings)

- Rationale: Increased use of RNs as care coordinators, navigators, etc. Note that there is variation in perspectives regarding whether RNs should be navigators or other staff such as community health workers. Thus, we estimate a range.

# Scenario 4: Behavioral health integration

- Scenario 4: Increase in employment of social workers and counselors.
  - 4A. Increase social worker and counselor employment by 10% in offices of physicians, offices of other health practitioners, outpatient care centers, home health care, other health care services, hospitals, nursing care facilities, and residential care.
  - 4B. Increase social worker and counselor employment by 20% in the same settings as outlined in 4A.

- Rationale: Increased integration of mental health/behavioral health and primary care. Stated need in interviews.

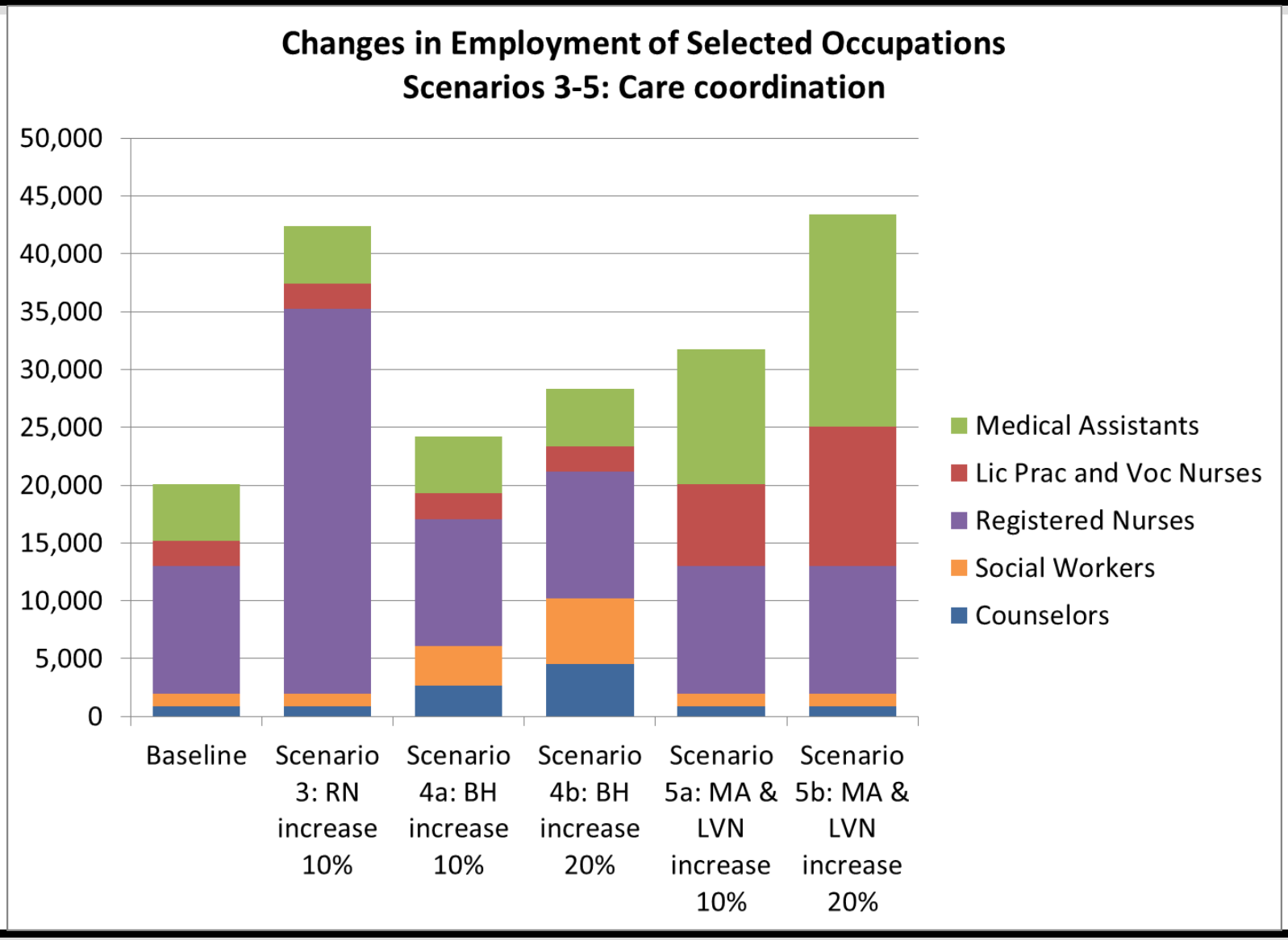
- Note that there weren't enough CHWs in the Census data to analyze them as a separate group. They would be part of scenarios 4 & 5.

# Scenario 5: Medical assistants and LVNs in expanded roles

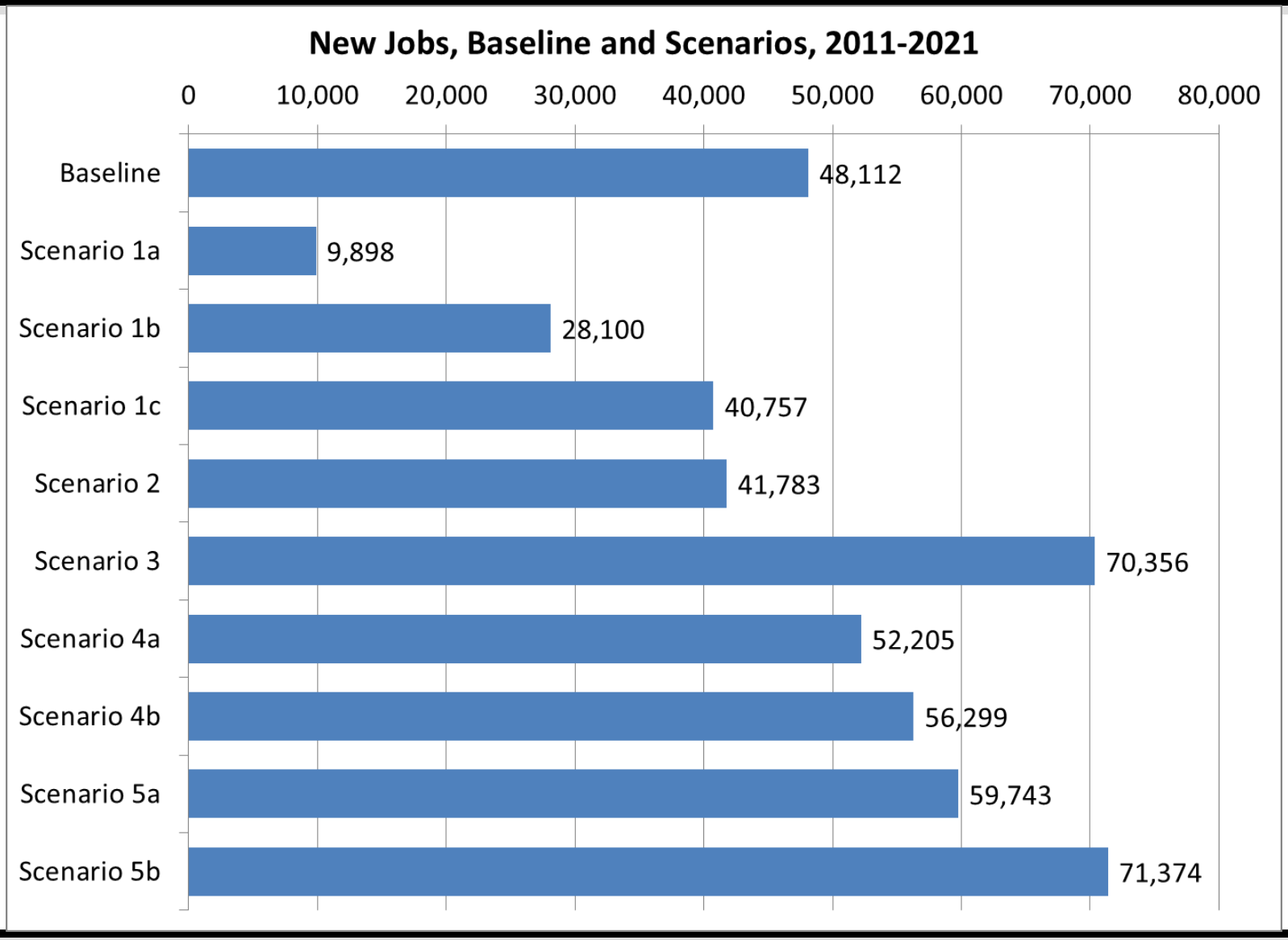
- Scenario 5: Increase in employment of medical assistants and LVNs
  - 5A. Increase medical assistant and LVN employment by 10% in offices of physicians, offices of other health practitioners, outpatient care centers, home health care, other health care services, hospitals, nursing care facilities, and residential care.
  - 5B. Increase medical assistant and LVN employment by 20% in the same settings

- Rationale: These occupations are needed to support MDs, NPs, and RNs, and will play a greater role in patient navigation, health coaching, and other patient-centered medical home functions. It is not clear the extent to which MAs will be used for roles versus LVNs or CHWs.

# Scenarios 3-5 Impacts



# Job growth, 2011-2021, in the alternate scenarios



# Strategic Considerations

Based on the findings, what action should be taken?

# Growth Areas and New Positions

- Growth Areas (Varies by Location and System)
  - Leadership across the board
  - RNs –
    - Inpatient setting: Labor and delivery, surgery, ICU, Peds, ER, night nurses
    - Ambulatory: high quality RNs in primary care
    - FQHC replenishment – many leave after 1 year of training
  - Navigators, care coordinators, transitional nurses (across continuum)
  - Non-licensed staff MAs/LVNs to supplement RNs and MD (somewhat technology driven)
  - Nurse Practitioners
  - Pharmacy Techs (help with medication management)
  - Lab Techs
  - Behavioral health – MFTs, psych techs, social workers, clinical psychologists
  - MDs – rural areas need this first
  - Receptionists/AAs – turnover with promotions and high cost of living areas
  - Academic Medical Centers need more generalists – hospitals becoming more specialized; need people with design thinking skills

# Growth Areas and New Positions

- New Positions (some have, some do not)
  - Care coordinators
  - Data analysts / data mining
  - Health coaches / preceptors
  - Nursing informatics
  - IT experts/support (ICD10)
  - Para professionals
  - Community Liaisons (e.g., college grads)

# Education

- Addressing the gap between education and practice
- Improve relationships with Schools
  - Examples - one with a faculty member becoming part of the care team
- Offer residency / internship programs for all RNs, NPs, and PAs
- Focus on teaching skills identified as a gap by the interviewees
- Develop school & on-the-job training for emerging care roles
- Ensure continued funding stream; no more cuts to education

| Soft Skills | Healthcare Landscape | Analytic Skills | Business 101 |
|---|---|---|---|
| – Professionalism<br>– Customer Service<br>– Communication (e.g., engage the patient in dialogue)<br>– Motivational Interviewing<br>– Peer to peer communication<br>– Strong work ethic<br>– Time mgmt.<br>– Function independently | – ACA skills – quality, pt. experience/satisfaction<br>– Pop. health and wellness<br>– Disease mgmt.<br>– Social determinants of health<br>– Case mgmt.<br>– Lean/Six Sigma<br>– Reimbursement | – Basic problem solving<br>– Understanding rationale – why are we doing the things we do?<br>– Data mining | – Business concepts<br>– Project management<br>– How to give constructive feedback<br>– Sensitivity training<br>– Team player |

# Regulatory

**Top regulatory changes that could help alleviate some of the challenges with the current workforce**

1. Changes in scope of practice for health care workers
   - More independence, especially in outpatient setting
     - E.g., MAs to draw blood, NPs to delivery babies in rural locations, HH aides to put ointment on a rash
   - CRNAs to provide more anesthesia services
   - Expand role of pharmacy tech – medication management; part of care team
   - Med lab tech – new emerging role
   - Don't over-regulate emerging roles such as care coordinators and variations on the Community Health Worker theme
   - Not just regulatory, but system specific as well – some organization have their own internal requirements
2. Allow more flexibility with nurse staffing ratios

# Regulatory

**Top regulatory changes that could help alleviate some of the challenges with the current workforce**

3. Continue to reform the payment system (needs to happen faster)
   - FQHC – reimburse for nursing visits and quality/care coordination
   - Allow MFTs to bill for services
   - Reimburse for digital technology/services
4. ACO regulatory changes needed
   - E.g., a NP sees patient, but PCP is billed and responsible for the patient
5. Reassess laws around forming partnerships
   - E.g., Cannot put together a network of FFS providers because it violates anti-trust laws
6. Continue to work with associations to push the correct policy/legislative changes needed